Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS1774AGC	A. BUILDING _____ B. WING _____	C 09/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOYALTON OF LAS VEGAS	3025 E RUSSELL ROAD LAS VEGAS, NV 89120

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Y 000	Initial Comments Surveyor: 28276 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a re-survey conducted in your facility on 9/8/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for eighty-nine (89) Residential Facility for Group beds for elderly and disabled persons and sixteen (16) Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. Twenty resident files were reviewed. The following deficiencies were identified:	Y 000		
Y 590 SS=H	449.268(1)(a) Resident Rights NAC 449.268 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility. This Regulation is not met as evidenced by:	Y 590		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 590	Continued From page 1 Surveyor: 28276 Based on record review and interviews on 9/8/09, the facility neglected 8 of 20 residents (Resident #1, #3, #6, #7, #8, #9, #15, and #17) by not ensuring they received their medications as prescribed by their physician. Findings include: The facility has a history of citations for failing to ensure residents receive their medications as prescribed by their physician. An annual survey was conducted at the facility from 1/29/09 to 1/30/09, and the facility was cited under Tag 878 for failing to ensure 13 of 20 residents received medications as prescribed by their physician (Resident #2, #3, #4, #7, #8, #9, #11, #12, #13, #14, #15, #16, and #18). On 2/20/09, the facility submitted a POC indicating their plan for compliance. The POC indicated: * Cited residents had their doctors orders compared to their MARs and audited by the Registered Nurse, Pharmacist, Resident Care Director and Executive Director. * Any discrepancies will be corrected. An in-service will be held for licensed nurses, resident charts, medication orders and medication administration records on 2/23/09. * The Resident Care Director or designee is responsible for transferring new orders to the MAR. The medication systems are to be monitored by random audits on an ongoing basis performed by the Resident Care Director, Executive Director, Executive Director or designee. * Date of correction 3/1/09. A resurvey was conducted on 3/24/09 and Tag 878 was cited for 1 of 19 reviewed residents (Resident #7). On 4/6/09, the facility submitted a	Y 590		

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Y 590	Continued From page 2 POC indicating their plan for compliance. The POC indicated: * The Medication staff will be in-serviced 4/9/09 on prescribed medication orders and implementation of any changes in medication orders. * Medication Administration Records will be monitored by random audits on an ongoing basis by the Resident Care Director, Executive Director or designee. * Date of correction 4/13/09. A complaint investigation was initiated on 5/11/09 and completed on 5/13/09. Tag 878 was cited for 10 of 20 residents not receiving medications as prescribed by their physician (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10). On 6/12/09, the facility submitted a POC indicating their plan for compliance. The POC indicated: * All ten resident medications were reviewed and were in the community. * The medication technicians would be re-educated on the medication policy during an inservice on 6/16/09. * The Wellness Coordinator or designee will be monitoring the medication administration records (MAR) with a shift-to-shift medication administration record review. * The Resident Care Director will be reviewing MARs on an ongoing basis for missing medications or changes in orders. * Medication Technicians (Med Techs) will notify the Wellness Coordinator when seven days of medications are left. * Date of correction 6/16/09. A complaint investigation was conducted on 5/28/09. Tag 878 was cited for 4 of 4 residents not receiving medications as prescribed by their physician (Resident #1, #2, #3, and #4). On	Y 590		

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Y 590	Continued From page 3 6/9/09, the facility submitted a POC indicating their plan for compliance. The POC indicated: *Medication Technicians will be re-educated on the medication policy. *The Wellness Coordinator reviewing MARs ongoing. Resident Care Director reviewing MARs on an ongoing basis for missing medications or change in order. A complaint investigation was conducted on 6/11/09. Tag 878 was cited for 2 of 4 residents not receiving medications as prescribed by their physician (Resident #2 and #4). On 7/13/09, the facility submitted a POC indicating their plan for compliance. The POC indicated: * The Medications of Resident #2 and #4 will be reviewed by a licensed nurse to ensure that medications are accurate and provided accurately to both residents affected. * A licensed nurse will review MARs monthly. * A quarterly audit will be conducted at least quarterly by a pharmacist. * The process will be monitored by the Executive Director and or designee. * Date of Correction 7/30/09. A complaint investigation was initiated on 6/19/09 and completed on 6/30/09. Tag 878 was cited for 1 of 3 residents not receiving medications as prescribed. On 7/29/09, the facility submitted a POC indicating their plan for compliance. The plan of correction indicated: * The physician orders for Resident #1 changed and implemented 6/15/09. Resident #1 moved out of the facility 6/19/09. * The Resident Care Director or designee would review the Medication Administration Record (MAR) at least once a month or after a physician ordered a change. * The process would be monitored by the	Y 590		

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Y 590	Continued From page 4 Executive Director by conducting random on-going review of the MARS. * Date of correction documented 8/30/09. A re-survey was conducted on 9/8/09 and the August and September 2009 medication administration records (MAR) up to 9/8/09 were reviewed. The MAR revealed that Resident #1, #3, #6, #7, #8, #9, #15 and #17 did not receive the listed medications as prescribed. Please refer to TAG 878. Severity: 3 Scope: 2	Y 590		
Y 878 SS=H	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Surveyor: 28276 Based on record review and interview on 9/8/09, the facility failed to ensure 8 of 20 residents received medications as prescribed (Resident #1, #3, #6, #7, #8, #9, #15 and #17). Findings include:	Y 878		

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Y 878	Continued From page 5 Resident #1: The resident was prescribed Metoprolol 25 milligrams (mg), (for hypertension), one tablet by mouth every day. A review of the resident's August 2009 medication administration record (MAR) documented the resident missed three doses of the medication on 8/12/09, 8/22/09 and 8/23/09. The Medication Technician (Med Tech) noted on 8/12/09 that medications were ordered and awaiting. The Med Tech initialed the August 2009 MAR from 8/13/09 through 8/21/09 indicating the resident received medication. On 8/22/09, the Med Tech noted the resident missed the medication and wrote, "meds were ordered awaiting". On 8/23/09, the Med Tech noted the resident missed the medication and wrote, "waiting for family to pick up." Resident #3: The resident was prescribed Tylenol 500 mg three tablets every morning and two tablets at noon "every tabs every evening." The Med Tech was unable to explain what "every tabs every evening" was supposed to mean. A review of the resident's September 2009 MAR documented the resident received the medication at 8:00 AM and at 5:00 PM instead of noon. Resident #6: The resident's August 2009 MAR indicated the resident was to receive Lasix 40 mg, one tablet every day (for hypertension). A review of the resident's August 2009 MAR revealed the resident missed one dose on 8/26/09. The Med Tech noted the dose was not given as the script was not filled out correctly. The resident was prescribed Spironolactone 25 mg, one tablet every day (for hypertension or edema). Review of the resident's July and August 2009 MARS indicated the resident missed three doses of the the medication on 7/29/09, 7/30/09 and 8/1/09. The Med Tech noted on the	Y 878		

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Y 878	Continued From page 6 back of the MARs the medication was not given, and on 8/1/09 noted the medications would arrive that day. Resident #7: The resident was prescribed Risperidone 1 mg take one tablet a day (for schizophrenia). A review of the resident's September 2009 MAR showed the resident received the medication at 8:00 am on 9/8/09. When the Med Tech was asked for the medication she reported she could not find the medication. The Med Tech admitted the resident did not get the medication on 9/8/09 as she could not find the bottle of medication. The resident was prescribed Acetaminophen 500 mg, (for pain), one to two tablets every four to six hours as needed (PRN). Review of the resident's September 2009 MAR revealed the resident received the medication as a scheduled medication at 8:00 AM and 5:00 PM from 9/1/09 through the am dose on 9/8/09. Resident #8: The resident was prescribed Metronidazole .75%, apply to the face every day after washing (for rosacea). The resident's September 2009 MAR listed the medication as an "as needed medication (PRN)," and there were no Med Tech initials on the September 2009 MAR to indicate the resident received the medication from September 1 - 8, totaling nine missed doses. Resident #9: The resident was prescribed Alendronate Sodium U-U 70 mg one tab weekly before breakfast (for the prevention of osteoporosis in post-menopausal women). Review of the resident's July 2009 and August 2009 MARs revealed the resident did not receive four doses of the medication on 7/7/09, 7/14/09, 7/21/09 and 8/4/09. The Med Tech documented	Y 878		

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Y 878	Continued From page 7 the medication was not given as the medication was unavailable. Resident #15: The resident was prescribed Warfarin Sodium 2.5 mg, one tablet by mouth every day in the morning (an anticoagulant used to treat or prevent blood clots). A review of the resident's August 2009 MAR showed the 8/5/09 dose was initialed by the Med Tech and the initials were circled. The documentation on the back of the MAR dated 8/6/09 indicate the medication was not given. A review done by a supervisor dated 8/6/09 confirmed the resident missed a dose. It is unclear if the resident missed the 8/5/09 or 8/6/09 dose of the medication. There was no record of what action was taken by the supervisor to correct the error. Resident #17: The resident was prescribed Diltiazem HCL, 1 pill every day according to the prescription label and the most recent doctor prescription (for hypertension). A review of the resident's September 2009 MAR revealed the facility gave the resident two pills every day. This was a repeat deficiency from the 5/13/09, 5/28/09, 6/11/09, and 6/30/09 State Licensure surveys. Severity: 3 Scope: 2	Y 878		
Y 885 SS=D	449.2742(9) Medication / Destruction NAC 449.2742 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable	Y 885		

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Y 885	Continued From page 8 method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Flushing contents of vials, bottles or other containers into a toilet shall be deemed to be an acceptable method of destruction of medication. This Regulation is not met as evidenced by: Surveyor: 28276 Based on observation on 9/8/09, the facility failed to ensure medication for 2 of 20 residents was destroyed (Resident #4 - Ditropan and Resident #17 - Glucosamine/Chondroitin). Severity: 2 Scope: 1	Y 885		
Y 925 SS=E	449.2748(5)(a)(b) Medication / Resident Transfer NAC 449.2748 5. If a resident is transferred to a hospital or skilled nursing facility, the residential facility shall hold the resident's medications until the resident returns or for 30 days after the transfer, whichever is less, unless the hospital or nursing facility requests the residential facility to provide the hospital or skilled nursing facility with the medications. If the resident does not return within 30 days after the transfer, the residential facility shall promptly dispose of any remaining medications. Upon the return of the resident from a hospital or skilled nursing facility, the residential facility shall, if there has been any change in the resident's medication regimen:	Y 925		

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Y 925	Continued From page 9 (a) Contact a physician, within 24 hours after the resident returns, to clarify the change. (b) Document the physician contact in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. This Regulation is not met as evidenced by: Surveyor: 28276 Based on observation and interview on 9/8/09, the facility failed to ensure medications belonging to 1 of 2 residents transferred out of the facility were destroyed (Resident #2). Severity: 2 Scope: 2	Y 925		